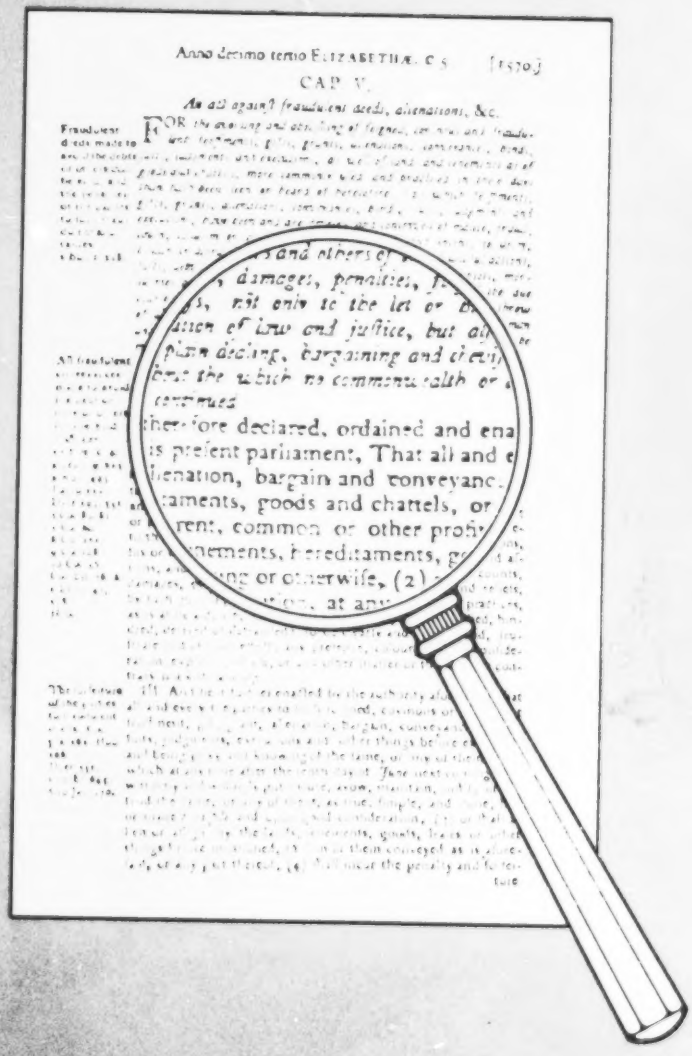
Law Reform Commission of Saskatchewan

Proposals for a Compulsory Mental Health Care Act

Report to the Minister of Justice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86-0302/

PROPOSALS FOR A COMPULSORY MENTAL HEALTH CARE ACT

Law Reform Commission of Saskatchewan
Saskatoon, Saskatchewan

Report to the Minister of Justice

March, 1985

The Law Reform Commission of Saskatchewan was established by *An Act to Establish a Law Reform Commission* proclaimed in November, 1973, and began functioning in February of 1974.

The Commissioners are:

Professor DOUGLAS A. SCHMEISER, Q.C., B.A., LL.B., LL.M., S.J.D., Chairman

Madam Justice MARJORIE A. GERWING

Mr. GORDON J. KUSKI, Q.C., LL.B.

Mr. Kenneth P.R. Hodges, B.A., LL.B. is Director of Research.

Mr. Michael J.W. Finley, B.A., M.A., LL.B., and Mr. C. Peter Thagard, LL.B. are the Legal Research Officers, and Mr. Roderick J. Wood, LL.B., LL.M., Dip. in Legislative Drafting and Mrs. Sandy Antonini-Ready, LL.B. are Legal Research Officers under contract. The secretaries are Mrs. Sandra Ritchie and Miss Pat Harasymchuk.

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The Law Reform Commission Act.

6. The commission shall take and keep under review all the law of the province, including statute law, common law and judicial decisions, with a view to its systematic development and reform, including the codification, elimination of anomalies, repeal of obsolete and unnecessary enactments, reduction in the number of separate enactments and generally the simplification and modernization of the law.

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Saskatchewan

Law Reform
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Saskatchewan

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The Honourable J. Gary Lane, Q.C.
Minister of Justice
Province of Saskatchewan
REGINA, Sask.

Dear Mr. Minister:

As part of its Medical-Legal Project, the Commission undertook a review of the law governing civil commitment. Tentative Proposals for a Compulsory Mental Health Care Act were released in November, 1981. Many organizations and individuals expressed their views on the Tentative Proposals. These views have been taken into consideration by the Commission in preparation of its final report.

Involuntary hospitalization of mentally disordered persons is one of the most difficult aspects of mental health care legislation. There is a need to provide adequate care to persons who require treatment in an institutional environment in order to be able to cope with problems of life. On the other hand, there is a need to protect the mentally ill from unwarranted restraint on their personal liberty.

Treatment of mental illness is fundamentally a medical matter. But treatment in an institution without the patient's consent is a legal matter. The Commission's final proposals seek an acceptable balance. Those who are confined to an institution should be protected by a court of law if long term institutionalization is required. The Commission has also endeavoured to reflect the spirit of the Charter of Rights and Freedoms in its proposals.

Pursuant to section 9 of The Law Reform Commission Act, the Commission now submits this, its final report recommending the enactment of a Compulsory Mental Health Care Act in the form set out herein.

Respectfully submitted this 28th day of February, A.D. 1985.

Douglas A. Schmeiser, Q.C.,
Chairman.

Madam Justice Marjorie A. Gerwing,
Commissioner.

Gordon J. Kuski, Q.C.,
Commissioner.

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PROPOSALS FOR A COMPULSORY MENTAL HEATH CARE ACT

I. INTRODUCTION

Civil commitment - the involuntary hospitalization of mentally ill patients - is unavoidably controversial. The controversy arises from the apparent conflict between two deeply held convictions of our society. On one hand, we accept a social responsibility to ensure that treatment is provided to individuals who may not, as a result of their illness, be able to recognize their need for treatment. On the other hand, we place a value on individual autonomy and self-determination. Forcing treatment upon an individual without his consent cannot be easily reconciled with the civil liberties ordinarily enjoyed by Canadians, and now guaranteed by the *Canadian Charter of Rights and Freedoms.*[1]

The recommendations in the report are premised on the belief that it is possible to strike a satisfactory balance between facilitating effective treatment of seriously disordered individuals, and protection of the civil liberties of those persons. Identifying where the balance lies is by no means an easy exercise. Controversy and differences of opinion about both ends and means will undoubtedly continue to affect discussions of civil commitment. Nevertheless, advances in psychiatry in the last half century, and a more enlightened public perception of the nature of mental illness, make it possible to determine the parameters of the problem with more assurance than in the past.

Until recently, civil commitment legislation was quasi-criminal: a disturbed individual was confined because his behaviour was regarded as a threat to public order, and authority to commit was usually assigned to courts of criminal jurisdiction. During the 1940's and 1950's, however, the legislative focus, reflecting a better understanding of mental illness, shifted toward treatment for the patient's benefit. Magistrates have had no authority to direct civil commitment in Saskatchewan since 1950.[2] Court involvement in the committal process was eliminated in most other North American jurisdictions at about the same time.[3]

Adoption of the "treatment model" inevitably led to a reassessment of extensive use of civil commitment. By the late 1950's, psychotropic drugs providing symptomatic control of depression and some major psychoses had become available. It became possible to release increasing numbers of patients into the community. Saskatchewan became a leader in the movement toward "de-institutionalization". In 1963, there were 3,100 patients in Saskatchewan mental hospitals; by 1983, only 200 patients remained. De-institutionalization did not, however, make civil commitment less controversial. Some patients continued to be hospitalized for long periods of time, and the legislative authority to commit was not re-examined in the wake of deinstitutionalization, but left committal criteria and procedure largely unchanged.[4] Stromberg and Stone have described American civil commitment legislation of the late 1950's and early 1960's in these terms:

> state laws generally had authorized commitment simply on the basis that a person was "mentally ill and in need of treatment." Due process was largely dispensed with on the ground that the goal of commitment was therapy, not punishment.[5]

That observation applies equally to existing Saskatchewan legislation.

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[1] Schedule B, *Constitution Act, 1982.*

[2] *The Mental Hygiene Act, 1950,* S.S. 1950, c. 74, s. 11. Under *The Mental Hygiene Act, 1936,* S.S. 1936, c. 91, s. 10, committal was authorized on the certificates of two physicians, or the warrant of the deputy minister of health "after investigation by a magistrate."

[3] World Health Organization, "Hospitalization of Mental Patients: A Survey of Existing Legislation," *International Digest of Health Legislation* (1955), 6:3-100.

[4] *The Mental Health Act, 1961,* S.S. 1961, c. 68, s. 11. See now R.S.S. 1978, c. M-13.

[5] Clifford D. Stromberg & Alan A. Stone, "A Model State Law on Civil Commitment of the Mentally Ill" (1983), 20 *Harv. J. on Legislation* 275, at 275.

There is an increasing awareness of the rights of mentally-ill patients. The very nature of the committal process makes protection of the rights of patients problematic. Certainly, the potential for mistake and abuse is real. Mental disorder is more difficult to diagnose than physical ailments. Prediction of behaviour and identification of treatment strategies is more difficult still. Analogies between commitment and imprisonment of persons convicted of criminal offences should not be carried too far. Nevertheless, a person accused of a criminal offence is guaranteed his liberty until he has been proven guilty beyond a reasonable doubt. He is not incarcerated merely because his behaviour is anti-social, or because he jeopardizes his own welfare. Yet is is possible to commit a person for these reasons in many North American jurisdictions. In a society that places a value on self-determination and freedom of choice, the decision to commit must be hedged with effective safeguards.

Concern for the rights of patients is both necessary and appropriate. However, application of an abstract notion of the right to self-determination to seriously disturbed patients who are unable to appraise their own need for treatment in any meaningful fashion may do as much harm as good. It can be argued that in some jurisdictions, the pendulum has already swung too far toward protection of patients' rights. In 1975, the American Supreme Court terminated a committal on the ground that no meaningful treatment has been provided to the patient.[6] Many lower courts interpreted the Supreme Court's decision to mean that civil commitment statutes which justify commitment on the basis of the interests or welfare of the patient are unconstitutional.[7] Other decisions have concluded that treatment of a committed patient without his consent may also be a violation of the Bill of Rights.[8]

The civil liberties issues which have made commitment a controversial matter in the United States in the last decade have already been introduced into the debate over committal crite[illegible] in Canada. Adoption of the *Canadian Charter of Rights and Freedoms* will almost certainly spark a new concern about civil commitment in Canada. It can be expected that the attack on traditional committal legislation mounted in the United States under the American Bill of Rights will find its counterpart under the Charter.

Identification of the proper balance between facilitating effective treatment and protection of the rights of involuntary patients is a legal problem, albeit one which can be resolved only with the aid of contemporary psychiatry and psychology. It must be stressed, however, that a law reform commission can contribute no more to the debate about commitment and other aspects of mental health care than a legal framework that will make it possible to protect civil rights without compromising effective treatment programs. Legislation cannot solve the difficult problems of civil commitment by fiat. It can prescribe limits, and establish parameters. In the last analysis, however, civil commitment will require a sensitive weighing of medical evidence guided by a concern for the patient's rights and welfare that will depend upon the judgment of the physicians involved in the committal process.

It should also be noted that the Commission's proposals are concerned only with civil commitment and legal regulation of the care and treatment of involuntary patients. The proposals, therefore, deal with civil commitment criteria and procedures, authority to provide treatment without consent, and

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[6] *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975).

[7] See, for example, *Suzuki* v. *Yuen*, 617 F. 2d 173 (9th Cir. 1980) and the discussion in Stromberg & Stone, "A Model State Law on Civil Commitment of the Mentally Ill", *supra*, note 5, at 276-77.

[8] *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), at 484.

review of committal and treatment decisions. The proposals take the form of a draft Compulsory Mental Health Care Act. That format has been chosen because it stresses the scope and limits of the Commission's proposals. The draft legislation has been designed, however, so that it could be included as part of *The Mental Health Act,* rather than enacted as an independent statute.

Other aspects of mental health legislation are primarily matters of organization, structure and funding, which are outside the scope of a law reform agency's expertise. It would be unfortunate if the focus of the Commission's report deflected attention from other pressing concerns about mental health in the province of Saskatchewan. Although deinstitutionalization has been a positive step, it has brought new problems in its wake. Significant numbers of patients who have been returned to the community suffer serious adjustment problems, and often face difficulties finding employment and suitable accommodation. Programs to provide adequate support for ex-patients in the community are vitally important. Saskatchewan has done a better job in this regard than many other jurisdictions in North America, but there is still substantial room for improvement.[9]

II. THE DECISION TO COMMIT — CRITERIA

1. Basic Issues

Criteria for committal adopted in most North American jurisdictions during the 1950's and 60's provided what has been called a welfare test:[10] involuntary hospitalization is justified to provide treatment in the interests of a person diagnosed as suffering from mental disorder. Section 16 of the Saskatchewan *Mental Health Act* establishes a typical welfare test as the minimum ground for committal:

> Subject to the regulations made under clause (b) of subsection (2) of section 49, a mentally disordered person who in the opinion of two examining physicians requires care, supervision and control for his own protection or welfare or for the protection of others, may be admitted to a facility as an in-patient and detained therein on the certificates of such physicians.

The minimum requirement for hospitalization under the Saskatchewan Act consists of two elements. The patient must be found to be mentally disordered; when such a diagnosis has been made, the committing physicians are entitled to hospitalize the patient if it appears to them to be in the patient's interest to do so. But "welfare" is a vague concept. In effect, the statute negates the patient's freedom to accept or reject treatment, and replaces it with a broad discretion in the committing physicians to exercise judgment on behalf of the patient. Presumably, such an invasion of the patient's rights is justified because the patient suffers from mental disorder. The definition of mental disorder provided by the Act is very broad, potentially including relatively mild behaviorial problems as well as severe psychoses. As a threshold requirement for substituting the committing physician's assessment of the patient's welfare for the patient's own, it casts a very wide net.

The de Vlieger Committee's report on rights in relation to health care adopted the principle that patients suffering from mental disorders should be treated in the same manner as other patients.[11] There are clearly limits on the extent to which that principle can be applied to severely disturbed patients. The right of a patient to be consulted about his care, and ultimately to withhold consent, assumes a capacity to assess options and make reasonably informed choices. It is the absence of the

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[9] See the Saskatchewan Mental Health Association's recent task force report, *Forgotten Minorities,* (1982).

[10] W.J. Curran and T.W. Harding, *The Law of Mental Health: Harmonizing Objectives,* Geneva: World Health Organization, 1978; see also W.J. Curran, "Comparitive Analysis of Mental Health Legislation in Forty-Three Countries: A Discussion of Historical Trends" (1978), 1 *International Journal of Law and Psychiatry 79.*

[11] *Report of the Committee on Rights in Relation to Health Care,* (The de Vlieger Committee), Regina, December, 1977.

capacity which, above all else, distinguishes the severely disordered patient in a psychiatric facility from other patients. Saskatchewan's committal criteria, however, potentially apply to a much wider class of patients than the severely disordered.

Despite the criticism of existing criteria outlined above, only a few Saskatchewan cases have come to the Commission's attention in which it appears that patients have been hospitalized when other forms of care and treatment would have been more appropriate. Physicians and facilities in Saskatchewan have used the power to commit with caution; but that caution is not imposed by *The Mental Health Act*. Even a few cases of abuse of the broad discretion created by the Act would justify adoption of more restrictive criteria. Moreover, experience clearly demonstrates that more restrictive criteria are workable. The caution exercised in practice indicates that the broad powers conferred by the Act are not necessary.

Section 7 of the *Canadian Charter of Rights and Freedoms* provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Section 15, which comes into force April 17, 1985, makes express reference to discrimination based on "mental or physical disability":

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The committal criteria contained in *The Mental Health Act* are difficult to reconcile with either section. That long term committal may be ordered simply on the certificates of two physicians applying a potentially vague welfare test suggests that the liberty of Saskatchewan citizens is not adequately protected in committal proceedings. It would be difficult to argue that mentally disordered persons are equal under the law when a patient who suffers from a relatively minor psychological disturbance potentially loses his right to make his own decisions concerning treatment.

Section 1 of the Charter does provide some latitude to the courts to avoid strict application of the Charter:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Since, however, the broad committal power established by *The Mental Health Act* is apparently unnecessary, it is unlikely that the courts will accept the proposition that it places "reasonable limits" on the rights of mentally disturbed individuals.

Canadian committal criteria have not yet been seriously challenged in the courts.[12] American courts, however, have had opportunity to examine similar provisions in state legislation. The American experience may provide some indication of the arguments which may be made under the Charter in regard to mental health legislation.[13] In *O'Connor* v. *Donaldson*, the United States Supreme Court concluded that the equal protection clause in the American Bill of Rights implies that:

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[12] The Charter has been considered in one case involving mental health legislation: *Re Jenkins and Government of Prince Edward Island* (1983), 150 D.L.R. (3d) 43 (P.E.I.S.C.). Until further cases have been heard, it will not be possible to predict the approach which Canadian courts will ultimately take under the Charter in this area.

[13] The possible application of American case law to Canadian mental health issues is analysed in Todd Wellsch, "The Right of the Civilly Committed Mental Patient to Refuse Treatment" (1983-84), 48 *Sask. L. Rev.* 269.

> [a] finding of "mental illness" alone cannot justify a state's locking up a person against his will and keeping him indefinitely in simple custodial confinement.[14]

On its face, the Saskatchewan *Mental Health Act* would permit such a course of action, as long as the confinement was adjudged by the physicians responsible for the patient's care to be in the patient's interests. It should be noted, however, that the Supreme Court did not invalidate state laws based on a welfare test. Donaldson had, in fact, been confined for 14 years without meaningful treatment. Whether committal under a welfare test that was followed by effective therapy would be acceptable was not addressed by the court. Perhaps unfortunately, lower courts in the United States have tended to hold that civil commitment provisions are unconstitutional unless they require proof of danger to self or others.[15] In the wake of those decisions, several American jurisdictions have adopted legislation permitting committal only upon proof of "danger to self or others". In Canada, the province of Ontario has followed suit.[16]

Such a test is proposed as an alternative to the welfare test because it presumably involves less intrusion into the rights of patients. It applies to a smaller class of mentally disturbed individuals. Since dangerousness implies severe disorder and a potential threat to others, the class of persons to whom such a test applies may be narrowly enough circumscribed to meet civil libertarian objections. This approach would probably be held to be acceptable under the *Canadian Charter of Rights*, if for no other reason than the apparent reasonableness of restraining dangerous behaviour.

But the test may miss the real point of concern about the civil rights of patients. A potential threat to self or others may not be the only reason why rights may be legitimately circumscribed. Freedom of choice is valued in our society because it is necessary for the development of individual autonomy and self-control. It is a hollow right for persons who cannot make reasoned decisions. Applied strictly, committal criteria which require proof of danger to self or others may deny treatment to individuals who are incapable of assessing their physician's advice, but who can only hope to recover from serious disorder through hospitalization. Just this objection was made by psychiatrists in Ontario when such an approach was adopted in that province. Brian Hoffman, a psychiatrist at the Clarke Institute of Psychiatry put the argument in these terms:

> The mentally ill person rarely causes physical harm to others, although they sometimes harm themselves; but when they are seriously ill, they always cause unimaginable pain to their loved ones as they damage their own family and social relationships, destroy their educational and employment opportunities, and damage their business and economic reputations.
>
> Many conditions are readily treatable. Schizophrenia, manic depressive psychosis, drug induced psychosis are responsive to many different forms of medication and psychotherapy. Every day I see patients who are thankful that their families and the doctors did what had to be done (certification), and grateful that we had effective therapies available for them and prevented them from further harming themselves in a physical, psychological or social sense.[17]

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[14] *Supra*, note 6, at 575.

[15] *Supra*, note 7.

[16] *Mental Health Act*, R.S.O. 1980, c. 262, s. 10, enacted S.O. 1978, c. 50, s. 4.

[17] B. Hoffman, "Bill will harm mentally ill, doctor argues", *Toronto Globe and Mail*, Feb. 1, 1978, 7.

A similar point of view has been expressed by American commentators. Darold Treffert, for example, has suggested that over-reaction to abuse of civil commitment has made it difficult for patients to "qualify" for hospitalization. He identifies legislation focusing attention on potential danger to the patient or others as the major source of the problem.[18]

Perhaps the best example of serious mental illness which can be effectively treated, but which is unlikely to lead to a committal under strictly applied criteria requiring proof of danger to self or others is manic depressive psychosis. By the very nature of the disorder, the manic depressive patient will often reject the suggestion that he is mentally ill. Instead, in a manic phase such a patient is apt to claim that he feels better than he ever has before. He becomes an exuberant risk-taker, who may, for example, sink his life savings in an improbable get-rich-quick scheme. He is apt to damage his relationships with those around him, and particularly those close to him. Yet a patient in a manic phase is unlikely to consider suicide, or to present a physical threat to others.

The primary purpose of involuntary hospitalization is treatment of serious disorder. Danger to self or others is not a satisfactory predictor of potential benefit from treatment, nor an exhaustive test for severity of the disorder. In addition, psychiatrists find danger to self or others difficult to predict. The only real virtue of such a test lies in the fact that it limits the number of potentially commitable patients. But it does not do so in accordance with defensible principles. In practice, the test may work more satisfactorily than in theory, but only because it is not strictly applied. If "danger" is given a broad enough meaning to encompass the kind of patient Hoffman is concerned about, it is reduced to a mere variation of the welfare test.[19]

An acceptable approach to involuntary hospitalization must directly address a central question: under what circumstances is it acceptable to limit a patient's rights by imposing hospitalization against his will? Whether it is articulated or not, the patient's capacity to give an informed consent to hospitalization is an important element in any committal decision. It is incapacity which provides a rationale for displacing the patient's right to accept or reject treatment with a physician's assessment of what is in the patient's best interests.

Incapacity should be regarded as a threshold requirement. It is clearly not in itself a sufficient ground for committal. It justifies intervention by the committing physicians, but does not provide a criterion for determining when committal of an incapacitated patient is appropriate. Even under the existing legislation, committals are ordered in practice only if the disorder is severe, the patient will benefit from the treatment, and the treatment can be effectively provided only in a hospital setting. If those factors, rather than a vague reference to protection and welfare, were incorporated in *The Mental Health Act*, the substantive rights of patients would be adequately protected. Such an approach would delimit the class of persons subject to committal proceedings, but on more appropriate grounds than criteria focusing on danger to self or others. It is legitimate to substitute the committing physicians' assessment of the patient's needs for that of the patient himself if he is unable to make a reasoned decision about treatment for himself and is severely disordered enough to make hospitalization for the purpose of treatment necessary to preserve or restore at least a minimal capacity to cope with the problems of everyday living.

The committal criteria proposed by the Commission are based on the approach outlined above. Each of the elements in the proposed criteria will be discussed in detail below.

2. Diagnosis of Mental Disorder in the Committal Process

Mental disorder is defined in paragraph (p) of section 2 of *The Mental Health Act:*

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[18] Darold A. Treffert, "The Practical Limits of Patients Rights", in *Psychiatry and the Legal Process*, Psychiatric Annals, 1977, at 227.

[19] Consider, for example, the Noval Scotia *Public Hospitals Act*, R.S.N.S. 1967, c. 249, as amended, which permits committals in cases in which the patient's "safety" or the "safety" of others is threatened. Peter MacKinnon suggests that this could 'encompass the same considerations which could lead a physician in Saskatchewan to conclude that a mentally disordered person required admission for his own "welfare", "Civil Commitment in Saskatchewan: A Reform Proposal" (1980-81), 45 *Sask. L. Rev.* 203, at 208.

> "mental disorder" means mental illness, mental retardation, psychopathic disorder, or any other disorder or disability of the mind. . . .

Mental illness is in turn defined in paragraph (s) of section 2:

> "mental illness" means a disorder of the mind other than psychopathic disorder or mental retardation, that results in a disturbance in a person's behaviour or feelings or thought and conversation and that results in mental distress or impaired ability to associate with others or results in a person's inability to react appropriately or efficiently to his environment and in respect of which mental treatment is advisable . . . .

Mental retardation is defined in paragraph (t) of section 2 of the Act:

> "mental retardation" means a condition of arrested or incomplete development of mind whether arising from inherent causes or induced by disease or injury.

Psychopathic disorder is defined in paragraph (dd) of section 2:

> "psychopathic disorder" means a persistent disorder of disability of mind other than mental illness that results in abnormally aggressive or serious socially disruptive conduct on the part of a person.

These definitions catalogue the principal forms of mental illness or behavioural dysfunction recognized by clinical psychology after the manner of textbooks current in the early 1960's.

It is probably undesirable to include a definition of mental disorder that is based on diagnostic criteria in committal legislation. Commitment is not justified because a patient's problems can be pigeon-holed according to a diagnostic manual. Not only is the classification of mental illness accepted by psychiatrists and clinical psychologists apt to change over time, but a diagnosis in itself does little to suggest whether commitment is appropriate or not. What is required is a functional rather than a diagnostic approach to the identification of disorders which may warrant consideration of involuntary hospitalization.

The real issue is whether the committing physician is satisfied that the patient's condition involves substantial impairment of his ability to function, and will be susceptible to effective treatment in a hospital environment. Logically, any definition of disorder could be avoided if commitment criteria are primarily concerned with the consequences of failure to provide treatment.[20] However, it is probably desirable to provide some extra protection for patients by establishing the proposition that the disorder must be both severe and most effectively treated in a hospital setting as a condition precedent to consideration of committal. While diagnosis provides some guidance to treatment and prognosis, it is not the diagnosis itself that the statute should be concerned with.

The model civil commitment statute which has been approved by the American Psychiatric Association establishes "severe mental disorder" as a condition precedent to committal. That term is defined in a functional manner:

> "*severe mental disorder*" means an illness, disease, organic brain disorder, or other condition that (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment or (2) substantially impairs behaviour as manifested by reason of disturbed behaviour.[21]

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[20] For that reason the Commission's *Tentative Proposals for a Compulsory Mental Health Care Act*, November 1981 suggested a minimal definition of disorder. The Commission has rejected that approach for the reason set out below.

[21] *Supra*, note 5, at 312.

The drafters of the legislation comment that:

> The Model Law recognizes the serious social decision that underlies commitment. Only a person suffering from a "severe mental disorder" should lose his liberty . . . . It must be stressed that the realities of a person's impairment, not diagnostic categories or nomenclature, determine the existence of a severe mental disorder. Thus, the issue is not the specific diagnosis alone, but whether a person's thought, perception, or other mental process is or is not substantially impaired.[22]

A similar definition of severe mental disorder should be included in Saskatchewan legislation, and the existence of such a severe disorder, rather than the existence of a broadly defined mental disorder, should be a threshold requirement for committal.

The definition of mental disorder contained in the Saskatchewan *Mental Health Act* is deficient in another respect. It includes both mental retardation and psychopathic disorder. In the opinion of most psychiatrists and psychologists, mental retardation is not a form of mental illness, and is usually not responsive to the treatment regimes traditionally available in psychiatric facilities. A mentally retarded individual may become mentally ill, and require committal, but in such a case involuntary hospitalization is justified because of the mental illness, not the mental retardation. It is likely that mental retardation has remained a ground for committal in most jurisdictions simply because hospitalization has often been the only way to provide care in a structured environment to some mentally retarded patients, and involuntary hospitalization the only means to place such a person in care against his wishes. In principle, mentally retarded individuals should not be hospitalized. Care for those individuals who are too severely retarded to function in the community should be provided in facilities designed for that purpose rather than in psychiatric wards. A range of alternatives to hospitalization is now available to mentally retarded individuals in Saskatchewan.[23] If confinement of a mentally retarded individual in a residential facility is necessary, committal proceedings are not an appropriate way to provide authority for that confinement. The Saskatchewan Law Reform Commission has recommended adoption of a Guardianship Act which would make it possible in appropriate cases to appoint a guardian with authority to determine a mentally retarded ward's residence and the scope of his freedom of movement.[24] There is no longer any justification for including mental retardation in the definition of disorders which may lead to civil commitment.

Psychopathic disorders are more difficult to classify than mental retardation. In the opinion of many psychiatrists and psychologists, a psychopathic disorder is the result of inappropriate conditioning, rather than a mental illness as the term is usually understood. For that reason, it is inappropriate to include psychopathic disorder within the definition of "severe mental disorder" for the purposes of committal legislation. It should be noted, however, that the definition of "severe mental disorder" proposed in the American Psychiatric Association's Model Act is flexible enough to encompass psychopathic disorders if, in the future, they are reassessed and come to be regarded as treatable mental illness. The definition of severe mental disorder adopted in the Model Act expressly provides that "[m]ental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder."[25] A similar qualification of the definition of severe mental disorder should be included in Saskatchewan legislation.

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[22] *Ibid.*, at 313.

[23] See *Forgotten Minorities*, *supra*, note 9.

[24] *Proposals for a Guardianship Act, Part I: Personal Guardianship*, January, 1983.

[25] *Supra*, note 5, at 312.

3. Incapacity and the Committal Process

It has been suggested above that incapacity is an essential threshold requirement for committal. But capacity tests have been criticized because incapacity is not something which can be diagnosed in the same manner as a mental disorder. Some physicians would prefer criteria which relate directly to those things within their particular expertise - diagnosis and treatment. While psychiatric evidence may bear on the question of capacity, the determination of capacity cannot be divorced from the legal and social values which give the concept significance. But commitment, by its very nature, involves more than medical issues; it can hardly be argued that either welfare or danger tests do not go beyond purely medical questions. Perhaps the real value of a capacity test as a threshold requirement lies in the fact that it requires the physician or other person empowered to make commitment decisions to confront the basic non-medical issue: on what grounds is he justified in displacing the patient's decision with his own?

It cannot be pretended, however, that incapacity is something which can be determined with precision. Adoption of a capacity test would require physicians to do no more than exercise their judgment to the best of their ability. Scientific certainty is not possible in any realistic commitment procedure.[26] The capacity criterion accepts that fact. In doing so, it also recognizes that non-medical issues are also involved in the commitment decision.

The capacity criterion can be made more workable in practice if it directs attention to the aspect of the patient's incapacity which is most relevant to the decision to commit. Committal is justified because a patient is in need of treatment, but unable to appreciate that need. Therefore, the committal criteria should require that the patient be found to lack capacity to make an informed decision concerning treatment. Just such a formula is adopted by the American Psychiatric Association's Model Act.[27] The commentary to the Model Act suggests how the capacity test could be applied in practice:

> A person lacks capacity if, due to his mental disorder or condition, he cannot understand the basic nature and effects of the proposed hospitalization or treatment. A person does not lack capacity simply because he refuses treatment, which he might do, for example, because he is a Christian Scientist or is risk averse (being excessively so in the physician's opinion). Understanding requires a fundamental appreciation of those aspects of the proposed treatment that a reasonable person would find significant in decisionmaking. A patient need not understand every technical feature of a proposed therapy.[28]

It should be noted that the Model Statute provides a definition of lack of capacity:

> *"lacks capacity to make an informed decision concerning treatment"* means that the person, by reason of his mental condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.[29]

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[26] That practical reality was recognized by the court in *Re Jenkins and Government of Prince Edward Island, supra,* note 12.

[27] The Model Act is reproduced in Stromberg & Stone, "A Model State Law on Civil Commitment of the Mentally Ill", *supra,* note 5, at 286.

[28] *Ibid.*, at 301-2.

[29] *Ibid.*, at 301.

The definition does provide some guidance to application of the capacity criterion. However, it probably does not add significantly to the simple statement that the criterion is met if the patient lacks capacity to make an informed decision concerning treatment. In fact, an expanded definition of lack of capacity may be difficult to apply in practice, and could lead to protracted litigation. For that reason, the Commission does not recommend adopting a definition of lack of capacity.

4. Prognosis, Treatment and the Committal Process

Since committal is justified only in order to provide treatment, it follows that committal criteria should permit involuntary hospitalization only when treatment is possible, and is reasonably necessary to protect or restore a patient's ability to function in the community. Furthermore, a patient should not be hospitalized without his consent unless the required treatment can be effectively provided only in a hospital setting. Such an approach is in fact adopted in practice in Saskatchewan under the existing legislation. Physicians are reluctant to commit patients unless they are convinced that the patient can be effectively treated in the facility. Read literally, on the other hand, *The Mental Health Act* would permit commitment of a patient simply in order to provide physical care without meaningful therapy. Similarly, while the policy of deinstitutionalization discourages hospitalization of patients who can be treated as out-patients, the Act does not prescribe such an approach. Adoption of more restrictive criteria which enshrine the treatment orientation of contemporary mental health care and the policy of deinstitutionalization would provide additional protection for patients' rights without interfering with the practice of conscientious physicians.

The American Psychiatric Association's Model Statute provides that a person suffering from severe disorder who lacks capacity to make an informed decision concerning treatment may be committed if, in addition:

> there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and
>
> * * * *
>
> as a result of the severe mental disorder, the person is (a) likely to cause harm to himself or to suffer substantial mental or physical deterioration or (b) likely to cause harm to others.[10]

The drafters comment that:

> The Model Law reflects the view that "[w]ithout some form of treatment, the state's justification for acting as parens patriae becomes a nullity". Even under the police power, if the mental health system offers only preventive confinement, then the criminal system should take responsibility for the person. The petitioner need not prove that treatment will cure the patient, but appropriate therapy must be available — and not just in theory, but "at" or "through" (that is, arranged by) the facility where the patient will be placed.

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[10] *Ibid.*, at 330.

> Second, the commitment must be consistent with the "least restrictive alternative principle." About twenty states impose a similar statutory requirement; about fifteen more identify the principle as a factor to be considered. At present, however, this requirement is more aspirational than real. As one study concluded, "[t]he least restrictive alternative is a nice phrase -unfortunately, few if any exist."
>
> Nevertheless, the Model Law includes this criterion so that the judges and legislators will confront the need for appropriate placement alternatives."[31]

The requirement in the Model Statute that, as a minimum, it must be demonstrated that the patient will "suffer substantial mental or physical deterioration" if he is not treated in the facility represents an attempt to reformulate the useful content of the welfare test in more precise terms. Treatment should not be imposed upon a patient unless it is clearly of benefit to him. If a condition is treatable, but only marginally so, the patient's interests are probably not well served by confining him against his will. The Commission is of the opinion that the criteria in the Model Act are satisfactory. However, two changes in that formulation would be desirable.

First, reference to "least detrimental alternative" should not be included in Saskatchewan legislation. Introduction of that phrase into Canadian law would require some attempt to define it. American experience suggests that a satisfactory definition is elusive. The content of the notion of least detrimental alternative can be preserved without introducing the phrase into Saskatchewan legislation. Commitment criterion should provide that a patient can be committed only if he requires treatment which is available only in a facility.

Second, the stipulation that a patient may be committed if, at a minimum, his condition will deteriorate without hospitalization may be too restrictive. The important consideration is not so much that the patient's condition will deteriorate, but that the treatment will stabilize his condition or provide some prospect that he may return to a normal level of functioning in the community. In this regard, the English *Mental Health Act, 1983* may provide some guidance. The Act requires that the treatment available in the facility must be "likely to alleviate or prevent a deterioration" of the patient's condition.[32]

5. Danger to Self and Others as a Criterion for Committal

While danger to self or others is not a satisfactory basis in itself for committal, such a test may provide a useful supplementary criterion for committal. It is likely that few patients who are dangerous to themselves or others would not also be candidates for committal under a test which required that treatment available in the facility alleviate or prevent the deterioration of the patient's condition. Nevertheless, it may be desirable in cases in which a patient clearly presents a danger to himself or others to provide for committal without requiring close consideration of the patient's probable prognosis and treatment. If, for example, a patient is suicidal as a result of a severe mental disorder, it would be appropriate to detain him and attempt treatment even if the prognosis under treatment was not good. For this purpose, the relatively weak formulation contained in the American Psychiatric Association's Model Statute, requiring evidence that the patient is "likely to cause harm to himself" or is "likely to cause harm to others" is satisfactory.

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[31] *Ibid.*, at 332-33.

[32] *Mental Health Act, 1983*, c. 20, s. 3(2)b) (U.K.).

6. Summary of Recommendations

The Commission recommends that Saskatchewan's civil commitment legislation permit the involuntary hospitalization of a patient only if the following criteria are met:

1. The patient suffers from a severe mental disorder, which should be defined to mean an illness, disease, organic brain disorder, or other condition that substantially impairs the person's thought, perception of reality, emotional process, or judgment, or which substantially impairs behaviour as manifested by recently disturbed behaviour. Mental retardation, epilepsy and other developmental disorders should not be included in the definition;
2. The patient lacks capacity to give an informed consent to treatment;
3. The patient is in need of treatment which can be effectively provided only in a facility; and
4. Either
   (a) there is a reasonable prospect that the treatment will substantially alleviate or prevent the deterioration of the patient's condition; or
   (b) the patient is likely to cause harm to himself or others.

III. COMMITMENT PROCEDURES

1. The Basic Commitment Procedure

Under section 16 of *The Mental Health Act,* a patient may be committed by two examining physicians. The physicians complete certificates of committal, after which the patient may be detained in the facility. It should be noted that if one of the committing physicians is not an admitting physician at the facility, the patient may not be hospitalized even though the committal is technically complete. Section 16 provides only that a patient who has been certified "may be admitted to a facility as an in-patient and detained therein . . .." Therefore the opinion of three physicians, one of whom is associated with the facility, is often required before a patient is involuntarily hospitalized.

Committal on the certificates of two physicians is a typical procedural pattern in North American jurisdictions. When the present procedure was adopted in Saskatchewan in 1950[33], it was a progressive step. It is clearly more acceptable than committal following a hearing before a lower court judge applying quasi-criminal procedures. However, committal by two physicians is essentially an administrative act with few procedural safeguards available to the patient.

The procedure may be open to challenge under the *Canadian Charter of Rights and Freedoms.* Section 7 of the Charter states that no person is to be deprived of liberty "except in accordance with the principles of fundamental justice." Although the scope of the phrase "fundamental justice" has not yet been determined by the courts, it is based on notions of natural justice which have been adopted by the courts.[34] Natural justice, which has recently been confirmed and expanded by the Supreme

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[33] *Supra,* note 2.

[34] See discussion in Patrice Garant, "Fundamental Freedoms and Natural Justice", in *The Canadian Charter of Rights and Freedoms - Commentary,* ed. Tarnopolsky & Beaudoin, Toronto: Carswell, 1982 at 278.

Court of Canada,[35] provides certain basic procedural rights whenever a judicial or quasi-judicial power is exercised. Traditionally, natural justice includes a right to be heard and make a defence, and a right to be dealt with impartially .[36] Fundamental justice may well apply to exercise of decision-making power which is not clearly judicial or quasi-judicial in nature; it may apply to the inquiry conducted by physicians under section 16 of *The Mental Health Act* just as the parallel due process clause in the American Bill of Rights has been held to apply to civil commitment statutes in the United States. The existing committal procedure does not guarantee the patient an opportunity to be heard, or to challenge the evidence upon which the committal may be based. For example, a physician may base a decision to commit in part on medical records prepared by other physicians or upon statements made about the patient by his friends and relatives. It may also be possible to argue that the committing physician is not impartial. In effect, he is both the judge and, through his observations, the principal witness in the proceedings.

Because of the difficulty inherent in a committal procedure based on certification by physicians, some commentators have suggested a return to judicial committal proceedings.[37] The decision to commit represents a massive invasion of the civil liberties of a patient. Traditionally, legal issues involving the liberty of a citizen have been left to the courts. A court of law is the recognized and accepted forum for making decisions of that sort. The rules of evidence and procedure which govern judicial proceedings guarantee that the minimal requirements of natural justice will be met.

There are, however, compelling reasons why committal decisions should not be made routinely by the courts. Experience under older committal legislation, which provided for hospitalization after a hearing before a magistrate, indicates that the rules of evidence and procedure do not ensure good decisions in themselves. In practice, magistrates relied heavily on medical evidence, in effect deferring the decision to psychiatrists. Because the commitment decision still technically lay with the court, however, responsibility for the decision was not always brought home to the physician testifying in court. The system probably encouraged commitment without proper investigation. Even if those defects in judicially-based committal were cured, other problems would still remain. Although this report has stressed that committal is not exclusively a medical decision, there is no doubt that medical expertise plays an important role in any decision to commit. A judge who is not trained in psychology or psychiatry is not the most appropriate decision-maker. Finally, court proceedings inevitably involve delay. Delay should be avoided in committal proceedings - the patient requires either speedy treatment or a speedy release. Delay is particularly unacceptable in a mental health care system which accepts the policy of deinstitutionalization. Most committals in Saskatchewan are terminated within two weeks of admission to the facility, and it is unlikely that a court based system could provide meaningful hearings within two weeks in most cases.

Delay is inherent in any procedural system in which a party's rights are protected by a full-scale hearing. While a specialized tribunal would be less subject to delay than the courts, the problem could not be eliminated entirely. For that reason, it is desirable to make a distinction between long term and short term committal.

Adoption of the policy of deinstitutionalization has made long term committal increasingly rare. According to information available to the Commission, it appears that at present in Saskatchewan no more than six to ten patients per year are admitted and detained for periods longer than 48 days. The small number of long term committals should not, however, lead to a cavalier attitude toward the rights of patients who are detained for long periods of time. Deinstitutionalization has been made possible by the development of effective psychotropic drugs which provide symptomatic relief from depression and major psychoses. However, a significant proportion of the patient population does not respond to such medication. In such cases, long term committal is a real possibility.[38]

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[35] See *Nicholson* v. *Haldimand - Norfolk Regional Board of Commissioners of Police*, [1979] 1 S.C.R. 311; and *Martineau* v. *The Mastqui Institution Inmate Disciplinary Board*, [1978] 1 S.C.R. 118.

[36] This first rule is referred to as the *audi alteram partem* rule; the second as the *nemo judex* rule.

[37] The American Psychiatric Association's Model Act, for example, requires a petition to the court for the basic "30 day" committal permitted under the statute.

[38] Recent research suggests that specific psychotropic agents are ineffective in from 20% to 37% of cases. See J.M. Davis, "Clinical Efficacy of Anti-anxiety Agents", 1979.

The potential for abuse is greater in cases of long term committal than in the ordinary cases. Any unnecessary detention of a person against his will is unacceptable; but when the detention continues for more than a few weeks, the injury done to the individual is compounded. If the criteria for committal are tightened in the manner recommended in this report, and patients are given an opportunity to require speedy review of committal by an independent tribunal, existing committal procedures would be acceptable to authorize short terms of committal. More extensive safeguards are necessary if a patient is detained longer than the normal committal period. The Charter of Rights may not require a committal hearing when a patient is committed for a short period of time. The practical necessity of providing a workable and speedy procedure may constitute a sufficient justification for a "reasonable" infringement of the patient's Charter rights under section 1. On the other hand, the Charter would almost certainly require a full scale hearing in cases of long term committal.

Although existing procedures are generally satisfactory for short term committal, two significant changes in the procedure would be desirable. Since the admitting physician at a facility must approve a committal before a patient is admitted, it would be desirable to recognize that fact in the legislation. Therefore, the legislation should provide that where the admitting physician is not one of the committing physicians, he must also complete a certificate of committal before admitting the patient.

Under the present Act, neither of the committing physicians is required to have training in psychiatry. It would be desirable to require that one of the physicians involved in the committal process be trained in psychiatry. It may not be appropriate in Saskatchewan, however, to stipulate that the physicians with psychiatric training be a registered specialist in psychiatry. The definition of psychiatrist adopted in legislation should include physicians recognized as such by the Director of Mental Health.

The distinction between long term and short term committal is of necessity somewhat arbitrary. As a practical matter, the duration of a short term committal should be long enough to include the majority of patients admitted to facilities at present. According to information available to the Commission, it would appear that the average committal in the province is for a period of about two weeks, but that a substantial number of committals may continue for as long as four weeks. For that reason, the Commission recommended in its Tentative Proposals that short term committal be defined as a four week period. In contrast, the American Psychiatric Association's Model Act, while not adopting a clear distinction between long and short term committal, recognizes a 30 day period as a standard committal period. The Saskatchewan Department of Justice after consultation with representatives of the Department of Health, recommended a 21 day "maximum period of initial committal" in its discussion paper, *Compliance of Saskatchewan Laws with the Canadian Charter of Rights and Freedoms*. The committal period should be as short as practically possible. If a 21 day period appears to be workable, the Commission is of the opinion that it should be adopted.

Although fundamental justice can be protected by decisionmakers other than courts, there are compelling reasons for requiring court approval of long-term committals. A decision to commit represents a massive invasion of the civil liberties of a patient. Traditionally, legal issues involving the liberty of a citizen has been left to the courts: a court of law is the recognized forum for making decisions of that sort. Public acceptance of commitment legislation would be enhanced by court involvement. The Commission is of the opinion that court approval should be required to extend a committal beyond three 21 day short term committal periods. Therefore, an application to court would be required only in cases in which the committal extends beyond 63 days. Because the average term of committal in the province is less than four weeks, court involvement would be necessary in a relatively small number of cases - fewer than ten per annum. In the Commission's opinion, this approach to committal will create a minimum court involvement while providing adequate protection for the rights of patients. It is unnecessary if the distinction between long and short term committal is adopted, to require court approval for all but emergency involuntary admissions. The draft legislation approved by the American Psychiatric Association, for example, makes just such a requirement. No doubt, that approach would protect patient's rights, but it ignores the very real concern of mental health care professionals that excessive reliance on the courts may delay effective treatment and make psychiatrists reluctant to seek committal even in appropriate cases.

2. Other Committal Procedures

A. Admission for Examination

In most cases, patients willingly submit to examinations which may lead to committal. Nevertheless, special procedures must be available to authorize examination and detention of patients who refuse to co-operate. Subsection 17(1) of *The Mental Health Act* provides:

> Subject to regulations made under clause (b) of subsection (2) of section 49, a mentally disordered person who in the opinion of an examining physician requires a psychiatric examination for his own protection or welfare or for the protection of others but who refuses to submit to such an examination may, after arrangements have been made with the medical officer in charge of a facility, be conveyed to a facility and examined therein by a physician.

This section also requires completion of a certificate by the physician who has ordered the examination. Technically, admission for examination under section 17 amounts to an independent committal procedure. Subsection 17(7) provides that a person admitted under the section "shall not be detained therein upon the authority of the certificate of the examining physician for more than fourteen days."

In practice, committal for examination under section 17 has occasionally attracted criticism. It permits a physician, who need not have psychiatric training, to detain a patient upon evidence which cannot be as complete as that which would result from prolonged examination and observation. Some problems are undoubtedly avoided because a patient committed under the section will not be admitted to a facility unless the admitting physician of the facility has at least minimal assurance that committal is appropriate. It is possible, however, to identify several respects in which additional protection for the patient could be provided without unnecessarily complicating admissions for examination.

The purpose of section 17 is to facilitate an examination to determine whether a patient ought to be committed. The authority given to a single physician to detain a patient and to transport him to a facility exists only for that purpose. The certificate of a single physician should be authority to do no more than detain the patient and transport him to a facility, where he can be examined and committed in the same manner as a patient who has voluntarily submitted to an examination.

In many cases, a patient can be committed immediately after he has been transported to the facility by the physician who arranged the admission for examination and the admitting physician. In facilities with small staffs, however, it may occasionally be difficult to complete the committal immediately. For that reason, the legislation should provide a maximum of 72 hours in which to complete the committal when a patient has been admitted for examination.

B. Admission arranged by the Police and Others

The Mental Health Act contains several other committal procedures in addition to those provided by sections 16 and 17. Section 27 permits the police to apprehend mentally disordered persons in certain circumstances:

> A person apparently mentally ill or mentally retarded and conducting himself, in a public place, in a manner that in a normal person would be disorderly may be apprehended without warrant by a constable or peace officer and detained for a period not exceeding 48 hours during which the question of his mental condition shall be determined by medical examination.

Subsection 24(1) provides for detention and examination upon a warrant issued by a provincial court judge:

> A person who suspects or believes that another person, who refuses to submit to a medical examination, is mentally disordered and in need of care, supervision and control for his own protection or welfare or for the protection of others, may lay an information on oath before a magistrate, in the presecribed form, and if upon inquiry the magistrate is satisfied as to the responsibility and integrity of the informant, he may thereupon issue his warrant in the prescribed form to apprehend the person named therein and cause him to be taken to the nearest facility for examination as an out-patient.

Subsection 24(2) provides:

> If a relative or friend of the alleged mentally disordered person so requests, the warrant may be directed to and executed by that relative or friend; otherwise it may be directed to and executed by a constable or peace officer.

Under subsection (3), the patient must be "examined forthwith" at a facility, and may be detained for 72 hours at the facility without his consent if the criterion for committal is met. Subsection (4) provides for an additional 14-day committal if the patient gives notice in writing "that he desires to remain in the facility" or a renewal certificate is issued.

Sections 24 and 27 appear to have a dual purpose. First, they have a quasi-criminal aspect. Under section 24, what amounts to emergency detention is justified because the mentally disordered person apprehended by the police is a threat to public safety. A concern about public safety may also be the motive for laying an information under section 24. Section 24 is also available in cases where an individual may cause harm to himself if he is not detained for treatment, and no physician is involved in the case. Even section 27 may occasionally be used for the same purpose.

Neither section is entirely satisfactory for either purpose. Section 27 is cast in very broad terms. Any person who is disorderly in a public place and "apparently mentally ill or mentally retarded" may be apprehended by a constable. Mental disorder is broadly enough defined under the Act to justify police intervention even when no criminal charge could be laid. Under the *Criminal Code*, "causing a disturbance" is an offence. However, something more than disorderly behaviour is required to justify conviction for that offence.[39]

It is sometimes suggested that the police should have broad powers to apprehend potentially dangerous mentally disordered individuals. The concern is motivated by a belief that broad police powers could prevent violent acts. However, prevention of such acts is impeded more by the difficulty in predicting violent behaviour and identifying potentially dangerous individuals than by the scope of police authority. When violent behaviour is manifested, criminal charges can usually be laid. In addition, the committal criteria proposed in this report, as well as the committal criteria in the present Act, are ordinarily broad enough to facilitate committal of disordered individuals who present a real danger to the public. For that reason, it is neither necessary nor desirable to extend the powers contained in sections 24 and 27 of *The Mental Health Act*.

The use of section 24 in an emergency situation to prevent a mentally disordered person from causing harm to himself is less controversial. However, even here there is potential for abuse. In some cases, section 24 may be invoked by the relatives of a mentally ill individual who has simply become troublesome to the family. The public perception of the degree of mental disorder which makes involuntary hospitalization appropriate may often be at variance with the standards applied in

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[39] The *Criminal Code*, R.S.C. 1970, c. E-34, s. 171.

practice by the medical profession. Therefore, committals which are not initiated by a qualified professional should include stronger protection for the rights of the patient than those found in the present legislation.

The Commission is of the opinion that both committal on the warrant of a provincial court judge and apprehension of disordered persons by police officers should be retained. However, criteria for detention in these situations should be narrower than for ordinary committal criteria. Both public safety and the safety of a mentally ill person in an emergency situation would be adequately protected if detention by non-medical persons was limited to cases where an individual, as a result of severe mental disorder, may cause harm to himself or others. In addition, it should be noted that sections 24 and 27 amount to independent powers of committal. In both cases, the legislation should do no more than authorize detention and transportation of the patient to a facility. If the patient is admitted to the facility, he should be committed under the ordinary committal procedure.

Sections 20, 22 and 23 of *The Mental Health Act* provide still other procedures for admission to a facility in cases in which criminal charges have been laid or a conviction for a criminal offence registered. Section 20 provides for admission and detention of individuals who have been found not guilty by reason of insanity, or unfit to stand trial. Section 22 permits transfer of a person imprisoned "under the authority of any act of Saskatchewan" to be transferred to a facility by order of the Lieutenant Governor-in-Council. Section 23 permits a judge to direct examination in a facility of a person who has been charged with an offence.

In the Commission's opinion, section 23 is inappropriate. Civil commitment should not be regarded as an adjunct of the criminal justice system. Under the authority of the *Criminal Code*, an individual may be examined to determine his fitness to stand trial or for other purposes connected with a criminal prosecution.[40]

Sections 20 and 22 are essentially administrative in nature. Detention of a person found not guilty by reason of insanity or found unfit to stand trial is justified by a warrant of the Lieutenant Governor in Council.[41] A person who has been convicted of an offence and sentenced to a term of imprisonment is detained under the authority of the court's order. In neither case is there any need to provide for committal to an institution. Sections 20 and 22 are contained in the present Act only because the structure of the Act implies that all patients in a facility must be committed to the facility. In the Commission's opinion, it would be more appropriate to leave the question of who may be admitted to a facility as an administrative matter to be determined by Regulations.

3. Voluntary Commitment

Section 15 of *The Mental Health Act* provides for voluntary hospitalization of a mentally disordered patient:

> (1) Subject to the regulations made under clause (b) of subsection (2) of section 49, a mentally disordered person may, subsequently to his examination by a physician and to completion of arrangements by the physician and the medical officer in charge of an inpatient facility for his admission thereto, be admitted to the facility as an in-patient and detained therein:
>
> (a) on his own request, if he is at least eighteen years of age;
>
> (b) on his request and that of his nearest relative, if he is at least sixteen but under the age of eighteen years of age; or

[40] See the *Criminal Code*, s. 465 (1)(c).

[41] See the Commission's *Tentative Proposals for a Lieutenant Governor's Review Board in Saskatchewan*, January, 1984.

(c) on the request of only his nearest relative, if he is under sixteen years of age or is otherwise not competent to make such request.

(2) Subject to subsection (3), a mentally disordered person admitted to and detained in a facility under subsection (1) shall not be detained therein for more than 24 hours after he or his nearest relative has given notice in writing to the medical officer in charge that he desires to be discharged therefrom.

(3) Where a mentally disordered person detained in a facility under subsection (1), or his nearest relative, has given notice to the medical officer in charge that he desires to be discharged from the facility, he may notwithstanding subsection (2), upon his having been personally examined by the responsible medical officer and upon issue by that officer of a renewal certificate and with the approval of the medical officer in charge, be detained in the facility for a period of fourteen days from the date of receipt of the notice by the medical officer in charge. The responsible medical officer shall conduct such examination separately from any other physician.

A patient who has been hospitalized under section 15, though he enters the hospital voluntarily, is not in the same position as a patient who consents to hospitalization for a physical ailment. Voluntary hospitalization under section 15 is a form of committal. The patient may be detained in a facility for up to 24 hours after his request for a discharge. During that time, he may be re-examined and committed for an additional 14-day period.

Some mental health professionals suggest that it is beneficial for the therapeutic relationship between doctor and patient for the latter to view his hospitalization as voluntary. Section 15 facilitates this by enabling the doctor to advise and persuade his certifiable patient to enter or remain in hospital willingly. One must attribute uncommon naivety to the mentally ill to suggest that they are unaware that they may be committed if they do not follow their doctor's advice. Often the doctor will have said or implied as much to the patient. Usually the patient will do as suggested for the same reason that we all generally follow medical advice. But occasionally, he may do so because he feels there is no real choice, and his feeling may be well founded in reality. In practice, section 15 may amount to a procedure for commitment which permits a doctor, by retaining the fiction of consent, to compel hospitalization without applying the admission criteria applicable to other forms of committal.

Section 15 is simply inconsistent with the voluntary status of any patient who has not been certified. The Saskatchewan Division of the Mental Health Association has commented on section 15 in the following terms:

> Forcing a person to give up their rights for up to 24 hours when they are seeking help on a voluntary basis seems inconsistent with the modern concept of mental health services. In the language of the present *Act* a person has to ask to be "detained" to receive services. There may be rare situations where a person who has come into the hospital on their own, experiences a state of anxiety, panic or other crisis, and needs to be dissuaded from leaving, but this type of situation should for the most part be handled by good quality professional care. The 24-hour clause as it exists leaves much to be desired.[42]

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[42] See *Tentative Proposals for a Compulsory Mental Health Care Act*, Law Reform Commission of Saskatchewan, November, 1981, at page 37.

If section 15 were repealed, doctors would still be able to advise their patients to enter an institution for treatment, but such hospitalization would be voluntary in fact.

4. Re-admission

Section 26 of *The Mental Health Act* provides that:

> (1) Where two physicians, one of whom shall be a responsible medical officer of a facility, are of the opinion that:
>
> (a) a person suffers from a mental illness and may be subject to a relapse if he does not continue with appropriate treatment; and
>
> (b) in the event of a relapse, the person is usually found to be in need of treatment and possible admission to a facility for his own protection or welfare or for the protection of others;
>
> each physician may issue a certificate to that effect.

The certificates are then authority for a medical officer of a facility to examine the patient and administer treatment, and to convey the patient to a facility for treatment and re-admission.

In effect, section 26 provides for recommittal without re-examination on the basis of opinions about the patient's prognosis recorded before the event which allegedly justifies recommittal. Section 26 is used only rarely in the province, and while some psychiatrists regard it as useful, others regard it as a potential source of abuse. In the Commission's opinion, the provision is unnecessary. A patient who suffers relapses will be subject to committal under the ordinary procedure.

5. Summary of Recommendations

1. Short term committal, for a period of up to 21 days should continue to be authorized by the certificates of two examining physicians, but one of the physicians should be a psychiatrist.
2. Where a patient is admitted to a facility under the authority of the certificates of two physicians, the admitting physician at the facility should be required to complete a certificate of committal after examining the patient, unless he was one of the physicians completing the initial certificates.
3. A patient should be informed of his rights upon admission to a facility, and should have the right to apply to the Review Board or to a court for immediate review of the committal.
4. A patient should not be detained for longer than three 21-day periods unless the medical officer in charge of the facility makes application to court.
5. Admission for examination should continue to be permitted on the certificate of a single physician, but the patient should be examined and committed or released as soon as possible after admission, and in any event, within 72 hours.
6. Police officers should continue to have authority to detain mentally disordered persons found in public places, but only if the person is seriously disordered and a threat to himself or others.

7. Committal for examination upon an information laid before a provincial court judge should continue, but only if the person named in the information is seriously disordered and a threat to himself or others.

8. "Voluntary committal", which authorizes detention for a 24 hour period after a patient who has not been involuntarily committed has requested discharge, should be abolished.

IV. TREATMENT

1. Authorization to Treat Involuntary Patients

Civil commitment exists to provide treatment for seriously disturbed patients. If treatment cannot be provided by the facility to which the patient has been committed, there is no justification for continuing the committal. Logically, therefore, authority to direct hospitalization without the consent of the patient must entail authority to provide at least some form of treatment without consent. At common law, a patient ordinarily cannot be subjected to treatment unless he gives an informed consent to the treatment. Curtailment of that right is easier to justify if lack of capacity to appreciate the need for treatment is a condition precedent to committal. Only an inability to consent, coupled with a clear and pressing need for treatment, provides a satisfactory rationale for dispensing with consent.

Not surprisingly, authority to treat involuntary patients who have been admitted under "welfare" committal criteria has been challenged in the United States under the Bill of Rights. In *Rennie* v. *Klein*, a New Jersey court held that an involuntary patient has a qualified right to refuse treatment based on a constitutionally protected right to privacy.[43] A similar approach has been adopted in other cases. The question of the patient's capacity has been a significant factor in those cases. For example, in *Roger* v. *Okin* it was observed:

> The weight of evidence persuades this court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication. This is particularly true for patients who have experienced such medication and, therefore, have some basis for assessing comparative advantages and disadvantages.[44]

It is possible that by adopting incapacity as a threshold requirement for committal, authority to treat can be protected from a challenge under the *Canadian Charter of Rights and Freedoms*. However, treatment of involuntary patients raises issues which should not be lightly dismissed.

The rule that a physician must ordinarily obtain the consent of his patient before undertaking a regime of treatment is not only a protection of the patient's right to self-determination. It is also one the principal tools in the law for the regulation of the practice of medicine. Together with the law of negligence, the consent requirement functions to discourage unnecessary or dangerous courses of treatment. In circumstances in which it is appropriate to dispense with consent requirement, other safeguards should be established to replace it. It should be noted that most of the cases in which American courts have held that treatment without consent was unjustified involved potentially dangerous or harmful forms of treatment. For example, in *Wyatt* v. *Stickney*, the court was of the opinion:

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[43] 462 F. Supp. 1131 (D.N.J., 1978).

[44] 478 F. Supp. 1342, at 1361 (D. Mass., 1979).

> Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, adversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice.[43]

In *Rennie* v. *Klein*, the court suggested that the scope of the patient's right to refuse treatment depended not only upon the patient's capacity, but also upon the availability of less restrictive or dangerous treatment. In the Commission's opinion, it is not possible to establish a single rule applicable to all forms of proposed treatment. It is useful to consider several categories of treatment:

1. Routine and established treatment involving known and manageable risk to the patient. This category would include psycho-analysis, and the administration of most types of psychotropic medication.
2. Accepted treatment procedures that involve a significant degree of risk to the patient, or which may be regarded by the patient as threatening or painful. Electro-convulsive therapy and aversion therapy are the most common treatments accepted at present which fall into this category.
3. Experimental therapy that involves a significant element of risk.
4. Psycho-surgery.

Regulation by statute of treatment procedures must not be unduly restrictive. Regulation is intended to place limits on authority to treat in the absence of consent; it is not intended to interfere with the judgment which must ordinarily be exercised by physicians who propose treatment regimes to their patients. Psychiatry and clinical psychology are evolving fields in which new treatments are continually adopted, and old treatments discarded. While legislation can establish parameters for treatment of involuntary patients to provide minimal safeguards against unwarranted treatment, the legislation should do no more than provide general guidelines.

Routine treatment should be authorized by the legislation without the patient's consent, and without imposition of formal procedures to obtain authorization for treatment. Some forms of psychotropic medication have significant side effects. The involuntary patient is rarely in a position to weigh the risks against the benefits of the treatment. Because administration of psychotropic medication has become widely accepted and standardized, regulation should be left primarily to guidelines established by the profession and individual mental health facilities.

Electro-convulsive therapy and aversion therapy present some special problems. Electro-convulsive therapy remains a controversial treatment. Although it no longer involves a significant degree of discomfort for the patient, and may be as safe a psychotropic drugs when properly administered, the very nature of electro-convulsive treatment makes its administration an emotive issue. Submissions to the Commission from patients' groups indicate a widespread concern among psychiatric patients and former patients about electro-convulsive therapy. Many fear that it is used too frequently or in inappropriate circumstances. In addition, there is a significant minority opinion amoung clinicians that the treatment should be avoided whenever possible. For those reasons, the Commission is of the opinion that administration of electro-convulsive therapy requires additional safeguards.

A patient who refuses to accept electro-convulsive therapy should be assured that his case will be carefully reconsidered before the treatment is administered. The Commission recommends that electro-convulsive therapy should not be performed on a patient who indicates his opposition to it unless an independent psychiatrist, who has examined the patient, concurs in the decision to administer the treatment. In such cases, both the psychiatrist responsible for the patient's treatment and the consulting psychiatrist should complete certificates setting out the rationale for the treatment.

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[43] 344 F. Supp. 373, at 380 (D. Ala., 1972).

Aversion therapy utilizes painful or unpleasant stimuli to modify a patient's behaviour. It is used extensively in some facilities in North America, but is not a routine treatment in Saskatchewan at present. If it is performed without the patient's assent, it may inspire the same sort of emotive response as electo-convulsive therapy, and it is surrounded by considerable controversy among clinicians. However, practitioners of aversion therapy are usually of the opinion that the effectiveness of the therapy is greatly reduced if the patient is not co-operative. For that reason, the Commission is of the opinion that aversion therapy should be regulated in the same way as electro-convulsive therapy.

Psycho-surgery has been perhaps the most controversial of treatments for mental disorders. The frontal lobotomy is no longer regarded as an effective treatment by most psychiatrists and psychologists, and is not being performed in the province at the present time. Even when it was regarded as an acceptable treatment by many psychiatrists, it was controversial because of the irreversible changes in personality and motivation which it caused. Recent research suggests that new forms of psycho-surgery may soon be available which avoid some of the risks of the frontal lobotomy. Nevertheless, the Commission is of the opinion that psycho-surgery should not be permitted at present in Saskatchewan. If new forms of psycho-surgery do become available, the legislation could be amended to permit them. But until new techniques have been proven, it is desirable to avoid psycho-surgery entirely.

As a general rule, legislation should not inhibit adoption of new treatments. Therapy which is strictly experimental and which may involve a significant degree of risk to the patient, however, should not be imposed upon involuntary patients. A patient who is incapable of consenting to treatment could do nothing to prevent assumption of an unknown risk factor if experimental treatment were not prohibited in such cases.

2. Summary of Recommendations

1. Routine and accepted treatment, including psychotherapy and administration of psychotropic medication, should require no special procedures or authorizations. Such treatment should be available even when the patient refuses it.
2. Electro-convulsive or aversion therapy should not be administered to a patient who refuses it unless it has been approved by two physicians who have independently examined the patient and completed certificates which set out the justification for the treatment.
3. Experimental therapy involving a substantial risk to the patient, and psychosurgery should be prohibited.

V. REVIEW

1. Review of Committal

The Mental Health Act establishes two mechanisms for review of committals. First, the certificate must be periodically renewed following a reassessment of the patient's need for hospitalization by physicians associated with the facility. Second, under section 31 of the Act, a certificate of committal may be reviewed by a review panel upon application by the patient or his nearest relative. The Act provides that:

> The function of a review panel shall be the investigation of complaints submitted under section 31, for the purpose of any such investigation, the members of the review panels who have all the powers inferred upon commissioners upon *The Public Inquiries Act*.

Under section 29, the Minister of Health must appoint a review panel for each facility. The panel consists of three persons, one of whom is a physician and another of whom is a solicitor. The panel is required to make a written report of its decision to the complainant, his nearest relative, and the

medical officer in charge of the facility in which the complainant is or has been a patient. Although the Act empowers the panel to hold a hearing and receive evidence from witnesses, the hearing is not mandatory.

Some form of independent review of complaints against committals is obviously a desirable protection for the rights of involuntary patients. It is likely that the courts will hold that provision for review is mandatory under the *Canadian Charter of Rights and Freedoms*. Section 7 of the Charter as noted above, provides that no person is to be deprived of liberty "except in accordance with the principles of fundamental justice". Since natural justice requires impartiality and a right to be heard, it can be expected that the courts will give considerable attention to the procedural requirements established by review legislation. In several important respects, the review panels as presently constituted appear to provide inadequate protection of patient procedural rights to meet the requirements of section 7 of the Charter. In addition, certain aspects of the existing review procedure, even if they are not repugnant to the Charter, have proved inadequate in practice.

It should be noted that the patient or his nearest relative must invoke the procedure. It is a trite principle that those directly affected by the decision should not have the right to initiate an appeal. It must be remembered, however, that mental patients are frequently unaware of their rights; when they are aware of them, they may not be able to assert them. The problem is not solved by entrusting the nearest relative with protection of the patient's rights. He is unlikely to be more informed than the patient, and he may even be an interested party in the sense that he first complained about the patient's behaviour or otherwise sought commitment. For that reason, the Commission is of the opinion that the right to initiate a review should be expanded.

The Charter will almost certainly require mandatory hearings as part of the review process. Under the existing legislation, the panel retains virtually complete control over the nature of the review. Subsection 31(4) of *The Mental Health Act* provides that:

> Upon receipt by the chairman of a review panel of a complaint in writing, the review panel shall forthwith carry out such investigation as it considers necessary to speedily determine the validity of the complaint and may invite the complainant and other persons considered by the review panel to be affected by the complaint to testify or produce evidence relating thereto. The complainant shall have the right to be personally present when any oral evidence is presented to the review panel, unless the review panel is of the opinion that this would be detrimental to his health, in which case he shall have the right to be represented. The complainant or his representative shall have the right of cross-examination.

It is possible for the review panel to proceed merely by receiving a written report from the personnel at a facility, and to make its decision on that basis without giving the patient an opportunity to be heard on his own behalf. That fact has led to a serious problem with review panels in this province. The practices of the review panels vary, depending on the members views of their duties, and on the initiative of the Chairman. There is an effort, in some panels, to operate as an efficient review tribunal. Others operate much less effectively. It appears that some review panels in the province do not regard reception of oral evidence, and thus representations on behalf of the patient, as appropriate in any case.

The Commission is of the opinion that review of committals by an independent tribunal should be retained. However, the review panel system established by the present *Act* should be substantially revamped. The system would be strengthened if the review panels for individual facilities were replaced by a single provincial review board with members throughout the province. The board chairman would be authorized to designate a panel of board members to hear appeals at particular institutions, but retain equal control over the system.

The review board should be properly constituted as a quasi-judicial tribunal, required to hold a hearing upon the request of a patient or other person with sufficient interest. Procedural rules should be adopted to ensure the patient's right to representation, to lead evidence before the board, and to cross-examine upon evidence presented by other witnesses.

2. Review of Treatment

Certification of a patient under the Commission's proposals, as under the present Act, provides authority both to detain a patient in a facility, and to provide at least routine treatment to the patient without his consent. Review of the exercise of the authority to treat is as essential a part of the legislation as is the review of the patient's detention. For that reason, the Commission recommends that a patient or other person with sufficient interest should have a right to make application to a review board for a review of treatment which has been proposed for the patient, or which the patient is receiving at the time the application is made.

Review of a treatment program by the review board will require the board to hear extensive medical evidence, and may in the result be a source of delay in the treatment program. For that reason, review should not be regarded as a routine matter. A distinction should be drawn between a case in which a patient initially refuses treatment, and a case in which the patient presses his refusal to the point of seeking a review. The proposed legislation authorizes continuation of routine treatment even when a patient objects. Only when a review has been demanded will it be necessary to have recourse to the independent scrutiny of the review board. In the Commission's opinion, this approach will strike a reasonably satisfactory balance between the patient's right to a review and the imperatives of an effective treatment regime.

3. The Patient's Advocate

Seriously disturbed individuals who have been involuntarily hospitalized are often not able to effectively assert their rights. Legislation should provide that a patient be informed of his rights upon admission to a facility, but that in itself is not enough. Nor will it always be satisfactory to rely upon intervention of friends and relatives of a patient to ensure that his rights have been respected. For that reason, the Commission recommends appointment of a patient's advocate, who might be characterized as an "ombudsman" for involuntary patients.

A study commissioned by the World Health Organization in 1978 indicates that appointment of some form of patient's advocate as a method of ensuring continuing review of the need for commitment and the appropriateness of treatment programs is attracting increasing attention in many jurisdictions. Ontario, for example, has recently established a patient's advocate program.

Typically, a patient's advocate is available to advise a patient of his rights, conduct formal investigations, and where it is felt appropriate, initiate a complaint on a patient's behalf. To carry out his duties, the patient's advocate must have free access to facilities and must be able to examine patients' records. He must be informed of admissions to facilities, and of circumstances, such as a refusal to submit to electro-convulsive therapy, which might appropriately involve the patient's advocate.

The Commission is not prepared, however, to make detailed recommendations for the administration and structure of a patient's advocate program. In Ontario, representatives of the patient's advocate's office have been appointed for each major facility. The program has not been in operation in that province long enough to determine whether or not that approach is necessary or desirable. The proposed legislation authorizes appointment of a patient's advocate, and confers the authority on him necessary to carry out his role. Decisions concerning the administration and staffing of the program will be best left to the newly appointed patient's advocate, the Department of Health, and the facilities involved.

4. Summary of Recommendations

1. The review board should continue to provide independent review of committal decisions, but the review board system should be enhanced by:
   (a) appointment of a provincial chairman to supervise the system on a province-wide basis;
   (b) adoption of procedural safeguards, including a right to demand a hearing, the right to counsel and the right to call and cross-examine witnesses.
2. A patient who objects to a program of treatment should have a right to make application to the review board for review of the treatment.
3. A patient's advocate should be appointed with authority to advise a patient on his rights, conduct informal investigations, and initiate complaints on a patient's behalf.

APPENDIX

An Act respecting the Compulsory Commitment of Mentally Disordered Persons

SHORT TITLE AND INTERPRETATION

Short Title

1. This Act may be cited as *The Compulsory Mental Health Care Act.*

Interpretation

2. In this Act:
   (a) "committal" means an involuntary committal to a facility pursuant to this Act;
   (b) "court" means the Court of Queen's Bench;
   (c) "director" means the Director of the Psychiatric Services Branch of the Department of Health;
   (d) "facility" means an institution, psychiatric centre, psychiatric ward, mental health clinic or any other building of portion thereof used for the care or treatment of persons with mental disorders, and designated for that purpose by regulation;
   (e) "medical officer" means the physician in charge of the care and treatment of persons in a facility;
   (f) "minister" means the Minister of Health;
   (g) "nearest relative" means the person first described in this clause who is readily available:
      (i) the spouse of a person unless they are living separate and apart;
      (ii) any child of the person who has attained the age of majority;
      (iii) either parent of the person;
      (iv) any brother or sister of the person who has attained the age of majority; or
      (v) any next of kin who has attained the age of majority;

   but where a person is a ward of the minister under *The Family Services Act*, "nearest relative" means the minister;

(h) "physician" means a duly qualified medical practitioner on the register of the College of Physicians and Surgeons of Saskatchewan;

(i) "psychiatrist" means a physician who holds a specialist's certificate in psychiatry issued by the Royal College of Physicians and Surgeons of Canada, or such other qualification as is acceptable to the director;

(j) "psychosurgery" means any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histiologically normal brain tissue, or which inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy where these conditions are clearly demonstrable;

(k) "severe mental disorder" means an illness, disease, organic brain disorder, or other condition that:

(i) substantially impairs a person's thought, perception of reality, emotional process or judgment; or

(ii) substantially impairs behaviour as manifested by recent disturbed behaviour;

but mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder.

REVIEW BOARD AND PATIENTS' ADVOCATE

Review board established

3. (1) The minister shall appoint a review board composed of such number of persons as set by regulation, at least one third of whom are physicians, and at least one third of whom are entitled to practise law in the province.

(2) The minister shall designate one of the members to be chairperson and another to be vice-chairperson of the review board.

(3) The minister may make such changes in the appointment of members as he thinks advisable.

(4) No person who is:

(a) an employee of the Department of Health;

(b) actively serving as a member of the medical staff of a facility; or

(c) a spouse, child, parent, or brother or sister of a person referred to in clause (b);

shall be appointed to the review board.

Patients' advocate

4. (1) The Lieutenant Governor in Council shall appoint a patients' advocate to advise and to protect the interests of persons committed to a facility.

(2) The patients' advocate shall:

(a) keep under review the circumstances of all persons committed to a facility;

(b) keep under review all certificates, applications, and orders of the court and of the review board;

(c) have access to the medical records of all persons committed to a facility; and

(d) have access to all persons in a facility.

(3) The patients' advocate may advise any person committed to a facility of his rights under this Act, and may initiate proceedings on his behalf.

COMMITTAL CRITERIA

Committal criteria

5. A person may be committed to a facility if:

(a) the person is suffering from a severe mental disorder;

(b) the person lacks capacity to make an informed decision concerning treatment; and

(c) there is a reasonable prospect that his disorder is treatable only at a facility;

and if:

(d) treatment will substantially alleviate the condition or prevent substantial mental or physical deterioration; or

(e) as a result of the severe mental disorder, the person is likely to cause harm to himself or to others.

COMMITTAL

Short-term committal

6. (1) A person may be committed to a facility on the medical certificates of two examining physicians, one of whom is a psychiatrist.

(2) Where the physician at the facility responsible for admissions is not one of the examining physicians, he shall examine the person and complete a certificate before admitting the person to the facility.

(3) No person shall be committed under this section after the expiry of 21 days from the date on which the first examination was made.

(4) A physician who completes a medical certificate under this section shall:

(a) state that he has personally examined the person separately from any other physician and after due inquiry is of the opinion that the person satisfies the committal criteria set out in section 5;

(b) state the facts upon which he bases his findings;

(c) indicate the date upon which the examination was made; and

(d) sign the certificate.

(5) Upon committal of a person to a facility under this section, the medical officer shall:

(a) inform the person of his right to have the committal reviewed, and of the function of the patient's advocate;

(b) give to the nearest relative notice of the committal, of the right to have the committal reviewed, and of the function of the patient's advocate; and

(c) give notice of the committal to the patient's advocate.

(6) The notice referred to in clauses (5)(b) and (c) shall be served by personal service or by registered mail.

(7) A committal under this section expires after 21 days from the date of the committal unless it is renewed.

(8) A committal under this section may be renewed for an additional 21-day period on the medical certificates of two examining physicians, one of whom is a psychiatrist; but no committal shall be renewed more than twice.

Admission for examination

7. (1) Where a physician is of the opinion that a person requires a psychiatric examination in order to determine whether he should be committed under section 6 but the person refuses to submit to such an examination, the physician may, after making arrangements with the medical officer of a facility, convey the person to the facility under a certificate for examination.

(2) A physician who completes a certificate for examination shall:

(a) state the facts upon which he bases his opinion that a psychiatric examination is required;

(b) indicate the date upon which the physician examined the person; and

(c) sign the certificate.

(3) After completing a certificate for examination, a physician may detain the person named in the certificate for a period not exceeding 24 hours if he is of the opinion that it is necessary for the protection of the person prior to his conveyance to a facility.

(4) Any person may, under the authority of a certificate for examination, apprehend and convey the person named in the certificate to a facility.

(5) No person shall be conveyed to a facility under a certificate for examination after the expiry of five days from the date on which the certificate for examination was completed.

(6) A person conveyed to a facility under this section shall be examined as soon as practicable, and within 72 hours of admission shall be either committed under section 6 or released.

Apprehension of person for examination

8. (1) Where a person has reasonable and probable grounds to believe that another person may be suffering from a severe mental disorder and is likely to cause harm to himself or to others, he may lay an information on oath before a judge of the Provincial Court; and if the judge, upon inquiry, is satisfied as to the responsibility and integrity of the informant, he shall issue a warrant to apprehend the person and convey him to a facility for examination.

(2) On the request of a friend or relative of the person named in the warrant, a warrant may be directed to and executed by that friend or relative, but in any other case it shall be directed to and executed by a constable or peace officer.

(3) A person apprehended under a warrant shall be conveyed to a facility within 24 hours, and within 72 hours of admission shall be either committed under section 6 or released.

Apprehension by peace officer

9. Where a peace officer or constable has reasonable and probable grounds to believe that as a result of severe mental disorder, a person who is in a public place is likely to cause harm to himself or to others, he may apprehend the person without warrant and immediately convey him to a physician or to a facility for examination.

Treatment on or pending examination

10. No treatment, other than emergency treatment, shall be provided to:

(a) a person detained under subsection 7(3);

(b) a person conveyed to a facility; or

(c) a person under examination at a facility;

without the consent of that person.

Committal by court

11. (1) Where a person has been committed to a facility under section 6, a court, on application by the medical officer, may order the committal for a specified or unspecified length of time of a person who satisfies the criteria set out in section 5.

(2) The court may make an interim order continuing the detention of the person, pending the final disposition of an application.

TREATMENT OF PERSONS COMMITTED

Mental health care and treatment

12. (1) The medical officer of a facility shall direct the care and psychiatric treatment of a person committed to a facility as is consistent with current mental health care and treatment, subject to any condition or restriction imposed by a court or by the review board.

(2) No experimental treatment that involves a substantial risk or psychosurgery shall be performed on a person committed to a facility.

(3) No electroconvulsive therapy or aversion treatment shall be performed on a person committed to a facility if that person objects to such treatment, unless the certificates of two psychiatrists are obtained authorizing the treatment.

(4) A psychiatrist who completes a certificate for electroconvulsive therapy or aversion treatment shall:

(a) state that the treatment is required in order to improve the person's condition, which would not otherwise improve, and that alternative treatments are less adequate; and

(b) sign the certificate.

Medical and surgical treatment

13. (1) Subject to section 12, the consent of a person committed to a facility shall be obtained before any medical or surgical treatment is authorized by the medical officer of a facility, if that person is able to give an informed consent.

(2) No sterilization, except where it is incidental to the treatment of some present or inevitable disease, or therapeutic abortion shall be performed on a person committed to a facility without an order of the court authorizing such treatment, if that person is unable to give an informed consent.

(3) A court shall not authorize sterilization or therapeutic abortion unless it is of the opinion that it is in the best interests of the person committed to the facility to do so.

(4) The medical officer of a facility may authorize the removal of a person committed to a facility to a place of treatment if he is of the opinion that the person requires medical, surgical or hospital treatment that cannot be provided at a facility; and the person, while so removed, is deemed to be committed to a facility.

DISCHARGE, LEAVE OF ABSENCE, TRANSFER OR ESCAPE OF PERSON COMMITTED

Discharge from institution

14. The medical officer of a facility shall discharge a person committed to a facility if he is of the opinion that the condition of the person no longer satisfies the criteria set out in section 5, and the committal thereafter is of no effect.

Leave of absence

15. The medical officer in charge of a facility may authorize the absence of a person committed to a facility for such period of time and upon such conditions as he may direct.

Transfer to another institution

16. (1) The director may authorize the transfer to another facility of a person committed to a facility.

(2) A person committed to a facility or the nearest relative of that person may make a request to the director for a transfer to another facility.

(3) The medical officer of a facility shall give notice by personal service or by registered mail to the person committed, his nearest relative and the patient's advocate of:

(a) the transfer or a refusal of a request for a transfer to another facility; and

(b) the right to apply to the review board for a review of the decision.

Escape and apprehension

17. (1) The medical officer of a facility may order the apprehension and conveyance to the facility of a person committed to the facility who has left without having been discharged under this Act, or who has not returned to the facility within the time specified by the medical officer under section 15.

(2) Where an order is made under subsection (1):

(a) a constable or peace officer; or

(b) a person authorized by the medical officer of the facility;

may without warrant apprehend and convey the person named in the order to the facility.

(3) If a person committed to a facility has been absent from the facility for more than 60 days, or if the period for which he has been committed has expired during his absence, the person is discharged from the facility and the committal and any order made under subsection (1) is thereafter of no effect.

REVIEW BY REVIEW BOARD

Review of committals and transfers

18. (1) On application by a person committed to a facility, the nearest relative, the patient's advocate or any other person with a sufficient interest, the review board, within 14 days of application, shall review:

(a) a committal under section 6;

(b) the treatment or proposed treatment of the person under section 12 or 13;

(c) a transfer or a refusal of a request for a transfer under section 16.

Annual review

19. (1) The review board shall review the committal of each person committed to a facility under section 11:

(a) within one year of a committal ordered by a court;

(b) at least once in every twelve month period following the review required by clause (a); and

(c) at any other time or times ordered by a court.

(2) The chairperson of the review board may set the hearing of the review earlier than the anniversary date of the committal, but in no case shall the review be commenced more than three months before the anniversary date.

(3) Unless a court otherwise orders, a person committed to a facility is discharged from the facility and the committal thereafter is of no effect if his committal is not reviewed in accordance with this section.

Powers of review board

20. (1) On a review of a committal made under section 6 or on an annual review under section 19, the review board may:

(a) dismiss the application; or

(b) order the release of the person.

(2) On a review of treatment or proposed treatment under section 12 or 13, the review board may:

(a) approve or reject any proposed medical or surgical treatment where the person is unable to give an informed consent;

(b) subject to subsections 12(2) and (3), approve or reject any proposed psychiatric treatment, and make such other condition or restriction as to the treatment as it thinks appropriate.

(3) On a review of a transfer or a refusal of a request for transfer made under section 16, the review board may:

(a) dismiss the application;

(b) order the transfer of the person to a specified facility; or

(c) order the return of the person to a specified facility.

PROCEDURE OF REVIEW BOARD

Designation of review board

21. On an application to the review board for review under section 18, or on an annual review under section 19, the chairperson of the review board shall designate three members of the review board, one of whom is a physician and one of whom is a lawyer entitled to practice law in the

province, to hear and determine the matter; and a decision of a majority is the decision of the review board.

Notice of hearing

22. (1) The review board shall give notice of the application or of the annual review to:

(a) the person who is the subject of the proceedings;

(b) the nearest relative of the person who is the subject of the proceedings;

(c) a guardian or committee of the person who is the subject of the proceedings;

(d) the director, or where the person who is the subject of the proceedings has been committed to a facility, the medical officer of that facility;

(e) the patients' advocate; and

(f) any other person having a sufficient interest in the proceedings.

(2) The review board may with the consent of the patients' advocate dispense with service on the person who is the subject of the proceedings if it is satisfied that it is in the best interests of the person to do so.

(3) The review board may dispense with service on a person referred to in clauses (1)(b), (c) and (f) if it is satisfied that it is appropriate to do so.

(4) Service of the notice shall be by personal service or registered mail.

Parties to proceedings

23. (1) Subject to subsections (2) and (3), every person who is entitled to receive notice of the proceedings is entitled to be a party to the proceedings, and has the right to attend the hearing and to be represented by counsel.

(2) The review board may with the consent of the patients' advocate exclude from the hearing the person who is the subject of the proceedings if it is satisfied that it is in the best interests of the person to do so.

(3) The review board may exclude from the hearing any person other than the director or medical officer, and the patients' advocate if it is satisfied that it is appropriate to do so.

Procedure

24. (1) Members of the public shall be excluded from the hearing unless the review board and the patients' advocate agree to the presence of members of the public or of a specified member or class of members of the public.

(2) A party to the proceedings may call witnesses and make submissions, and may cross-examine witnesses.

(3) The review board is not bound by the rules of evidence, and has full authority to control the procedure of the hearing and to rule upon any motions or objections.

(4) The members of the review board shall have all the powers conferred upon commissioners by *The Public Inquiries Act*.

(5) Unless all parties to the proceedings agree otherwise, an application under section 18 or an annual review under section 19 shall be heard at the facility in which the person is committed.

(6) The review board may prohibit the publication of reports of the hearing or of the names of persons involved in the hearing.

Decision of review board

25. (1) The review board shall render a written decision giving the reasons for its decision within seven days of the hearing.

(2) A copy of the decision shall be given to the patients' advocate and to the medical officer of a facility if the person has been ordered to be committed to a facility.

APPLICATIONS TO COURT

Court may hear matter de novo

26. (1) On application by a person committed to a facility, the patients' advocate, or any other person with a sufficient interest, the court shall hold a hearing *de novo* into the committal, transfer, or any proposed treatment of the person, whether or not a review board has held a hearing into the matter.

(2) Where the review board has held a hearing into the matter, the court may, with the consent of the parties to the application, hold a hearing on the record of the review board.

(3) The court upon hearing the matter may:

(a) order the release or transfer of the person committed to a facility;

(b) order the committal of the person for a specified or unspecified length of time;

(c) approve or reject any treatment of the person committed to a facility;

(d) make any other order that it thinks necessary to protect the interests of a person committed to a facility.

Procedure

27. (1) Notice of an application by a medical officer for a committal under section 11 or an application for review under section 26 shall be served on:

(a) the person committed to the facility;

(b) the nearest relative of the person committed to the facility;

(c) a guardian or committee of the person committed to a facility;

(d) the medical officer of the facility;

(e) the patients' advocate;

(f) any other person having a sufficient interest in the proceedings.

(2) Subject to subsections (3) and (4), every person who is entitled to receive notice of the proceedings is entitled to be a party to the proceedings.

(3) The court may with the consent of the patients' advocate dispense with service on the person committed to the facility if it is satisfied that it is in the best interests of the person to do so.

(4) The court may dispense with service on a person referred to in clauses (1)(b), (c) and (f) if it is satisfied that it is appropriate to do so.

(5) The court may order an investigative report on any of the matters in respect of which the application is made.

Appeal to Court of Appeal

28. An appeal lies from an order of the court to the Court of Appeal.

GENERAL

Communication with person in facility

29. (1) Subject to subsection (2), no person shall open, examine, withhold or interfere with the delivery of any written communication sent by or written to a person committed to a facility.

(2) If the medical officer of a facility or a person acting under his authority has reasonable and probable grounds to believe that the contents of the communication to the person would:

(a) interfere with the treatment of the person; or

(b) cause the person unnecessary and damaging distress;

he may open the communication and examine its contents; and if he continues to believe that it would interfere with the treatment or cause the person unnecessary and damaging distress, he shall deliver it to the patients' advocate.

(3) Subsection (2) does not apply to any communication sent to the person by a solicitor, the patients' advocate, the provincial ombudsman, a member of the Legislative Assembly, or a member of the review board.

Voluntary committal

30. Nothing in this Act prevents the voluntary admission of a patient to a facility.

Civil liability

31. No action or other proceeding for damages lies against any person for an act done in good faith and without negligence in the exercise or intended exercise of any authority conferred by this Act.

Regulations

32. For the purpose of carrying out the provisions of this Act according to their intent, the Lieutenant Governor in Council may:

(a) prescribe the form of all certificates, warrants and other documents;

(b) designate any institution, psychiatric centre, psychiatric ward, mental health clinic or any building or part thereof used for the care or treatment of persons with mental disorders as a facility;

(c) prescribe the number of persons that compose the review board;

(d) provide for the remuneration and expenses of review board members;

(e) provide for the transfer of persons from one facility to another, and from a correctional or other institution to a facility for examination under this Act;

(f) prescribe the manner by which the director may recognize a physician to be qualified as a psychiatrist;

(g) prescribe further review board procedure not inconsistent with the procedure set out in this Act.